Minnesota Hospital Association

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October 8, 2012

TO: Members of the Care Integration and Payment Reform Work Group

RE: Work Group's Draft Recommendations

On behalf of our members, which include 145 hospitals and health systems throughout Minnesota, the Minnesota Hospital Association (MHA) is grateful for another opportunity to provide feedback and comments regarding the Care Integration and Payment Reform Work Group's (Work Group) draft recommendations dated September 25, 2012. We hope that these comments will help you improve and revise your recommendations before they go to the Health Care Reform Task Force.

MHA submitted an earlier comment letter raising our suggestions and concerns. Instead of reiterating the content of that letter, the following comments are intended to supplement and augment that letter, specifically with respect to the changes in the draft recommendations since August.

At the outset, MHA considers the Work Group's overarching objectives as aligned with MHA's health care reform priorities and the direction we want our health care system to continue driving toward. None of the recommendations include any cost estimates. MHA hopes that the Work Group will include a disclaimer or other statement that instructs policy makers to evaluate each recommendation with an eye toward the costs of implementation and the potential savings it might generate. This evaluation seems particularly important for recommendations that involve state agencies collecting data, contracting with third parties or otherwise engaging in activities other than providing health care, insuring against the costs of health care or improving public health.

Also, MHA would like the Work Group to recognize providers' need for flexibility to redesign how they deliver care. All of the recommendations are premised on an implicit expectation that the health care delivery system can reform itself to deliver better care to more people at less cost. To accomplish these goals, providers need flexibility to deploy their talented workforce in new ways, to use physicians and nurses differently in team-based ways, and to interact with patients in a less resource-intensive manner. Accordingly, some regulations in place today might need to be lifted and others that have been proposed, such as government-mandated nurse-to-patient staffing ratios that lock in costs and staffing patterns, need to be rejected. If the Work Group's strategies are to be implemented successfully, the health care delivery system will need the flexibility for innovation and experimentation that the Work Group presumes will exist. For additional examples of regulatory relief that will help providers reduce costs, eliminate

administrative waste and continue to deliver the highest quality care in the country, MHA has included a report that we provided to Minnesota Management and Budget and the Legislature last year.

With regard to the specific content of the draft recommendations, the following comments are arranged in an order that follows the sequence of the draft recommendations. We hope that this organization makes our comments easier for you to follow and trust that you will be able to discern those subjects that are of greater importance to our members.

Goal

As we stated in our previous letter concerning an earlier draft of the recommendations, MHA agrees with the general goal and direction the Work Group aims to address. We question, however, the unintended consequences and harmful disruptions of the three-year timeline. To reduce health care spending to the rate of inflation in only three years is admirable when taken in isolation and when reflecting solely on the need to contain health care cost growth. Such a limited view, though, is misleading and potentially disastrous.

It is an understatement to say that it is difficult to predict what will happen to health care spending and utilization if the Affordable Care Act's (ACA) reforms go into effect in 2014, or if the ACA is repealed or substantially revised. Placing cost containment markers in the ground today seems presumptuous.

More importantly, hasty spending reductions could put patient care at risk. MHA cannot support artificially restraining health care spending for the sake of achieving an attractive timeline or popular target if doing so will detrimentally impact the quality or safety of patient care or impose barriers to access to care.

Strategies

1. **Advance Total Cost of Care Contracting by DHS for Minnesota Health Care Programs**

   The draft recommendations state that the Department of Human Services (DHS) should expand the extent of Total Cost of Care (TCOC) contracting and integrate long-term care, local public health and human services into those contracts. MHA is concerned that these TCOC contracts will attempt to encompass too many services and will diverge from the momentum already in place in private sector contracts.

   MHA appreciates the interest in better aligning social services, public health and long-term care with today's providers of preventive, acute, post-acute and chronic illness. Few, if any, organizations with lines of accountability and sufficient capacity exist to enter such contracts with DHS. Accordingly, MHA encourages the Work Group to consider interim strategies that would foster the integration of these various providers in a more incremental fashion.

Also, MHA is concerned that commercial payers have already moved to TCOC contracts. Our members are worried that TCOC contracts with DHS will vary too significantly from those they have with other payers creating more confusion, misaligned incentives and fragmentation. Because these arrangements are still in an experimental phase, MHA suggests that the Work Group revise this strategy to advance TCOC contracts with health care providers in a manner that leverages and aligns with those in the private sector.

MHA believes that the Work Group's intention is more accurately reflected in language of "collaboration," "alignment," or "cooperation" than in language of legal integration or merger. At a minimum, greater definition or description of the Work Group's expectations regarding "integrate" will be helpful.

2. **Facilitate improved integration of behavioral health and primary care services.**
MHA supports this strategy and appreciates the Work Group's attention to mental and behavioral health care as an essential component for health care system improvement. MHA suggests that subpart d. be amended as follows: "_____ shall support the location of primary care clinicians in community-based mental health centers and mental health providers in primary care clinics by _____." As the Work Group notes, most mental health care is delivered in primary care clinics so it is important to integrate mental health into those clinics as well as bringing primary care into community-based mental health centers.

3. **Set public and private payer performance targets to support improved population health, patient health care experience and quality of care, and reduced cost growth.**
MHA does not support strategies that involve the state government setting performance targets for contracts negotiated between private parties.

4. **Explore the need for a limited set of common standards for TCOC-contracting entities and develop such standards, if appropriate.**
MHA urges the Work Group to move cautiously toward establishing regulatory restrictions that will hamper development of and experimentation with TCOC contracting arrangements. Although Minnesota's health care providers are at the forefront of TCOC contracting, these arrangements are still new and evolving. Medicare's shared savings program, for example, has experienced a large number of groups interested in becoming an Accountable Care Organization (ACO) as well as a wide variety of structures and make-up of ACOs. Cementing certain rules or requirements might preclude innovations.

5. **Guide a process for comprehensive performance measurement of TCOC-contracting provider entities and other provider organizations in achieving health and cost goals.**
MHA has supported the Statewide Quality Reporting and Measurement System and believes that this existing mechanism can be utilized to achieve much of the Work Group's intended strategy. Instead of creating a new process, state contracts, etc., MHA encourages the Work Group to leverage this existing mechanism for developing and agreeing upon uniform measures to be used by providers and plans.

As stated in our previous letter, MHA continues to be concerned with the amount of measures and new reporting that appear to be outcomes from the Work Group's recommendations. Today, providers often question whether the amount of resources spent on collection and reporting of data are imbalanced with respect to the resources spent on quality improvement. MHA appreciates the Work Group's inclusion of language that cautions against measures that are administratively burdensome. Nevertheless, the number and scope of new measures and reporting described in the draft recommendations seems to presuppose significant costs and burdens for providers.

6. **Provide technical assistance to targeted providers to help these providers succeed in the future with a system in which providers are contracting for the Total Cost of Care.**
   MHA appreciates the Work Group's interest in helping providers transform themselves for a TCOC environment. The draft recommendations fail to describe what kind of assistance will be provided. Accordingly, it is difficult to discern whether the Minnesota Department of Health (MDH), the Office of Rural Health and Primary Care, or any of the other named organizations are suited to provide such advice or expertise and, if so, at what cost.

   Likewise, MHA questions whether MDH, an agency that is not involved in negotiating contracts with health plans or providers, is best equipped to facilitate discussions between payers and providers interested in TCOC contracting.

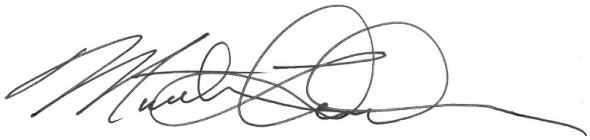
7. **Address barriers to clinically appropriate data sharing while rigorously protecting against unauthorized sharing and disclosure.**
   As stated in our previous letter, MHA continues to believe that this is the single most important strategy in the draft recommendations. Without better access to clinically appropriate patient data, care coordination will remain elusive. MHA believes that this strategy is so fundamental and mission-critical that the Work Group should consider making it the first recommended strategy and explicitly singling it out as a foundational first step that must be overcome before any of the other strategies can bear fruit.

8. **Enhance the market availability of health insurance products that foster consumer accountability for health behaviors and create incentives for consumers to use high value providers.**
   MHA supports the direction of this strategy. It is unclear what incentives already exist in the market, or what impact new community rating regulations and the Health Insurance Exchange market will have on such products.

9. **Pilot the concept of Accountable Communities for Health**
   MHA supports the suggestion of using pilots to test new models of care delivery and payment methodologies. As stated in our previous letter, MHA continues to be concerned about the recommendation that "Accountable Communities for Health shall be represented on the boards of TCOC-contracted entities ..." TCOC-contracted entities are, generally speaking, private organizations with their own legal standing and board selection process. MHA does not support a recommendation that would lead to requiring private entities to change their board composition to include members of another organization or government, or to have board members with fiduciary obligations that run to the Accountable Community for Health rather than the TCOC-contracted entity.

MHA appreciates the opportunity to share these comments and suggestions. If the Work Group or any of its members have questions or concerns about MHA's comments, please feel free to contact me anytime.

Sincerely,



Matthew L. Anderson, J.D.
Vice President, Regulatory/Strategic Affairs

Enclosure

MHA Regulatory Relief Work Group

January 2012

Report to the MHA Board of Directors and Recommendations

Minnesota Hospital Association

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Introduction

The Minnesota Hospital Association (MHA) Board of Directors instructed MHA staff to assemble and convene a work group of representatives from the membership to identify and prioritize ways to reduce the administrative and reporting burdens faced by Minnesota's hospitals and health systems. The charge for the work group was:

> ***Identify, evaluate, and recommend statutory or administrative changes that the association can pursue to reduce regulatory burdens and administrative costs without negatively impacting patient safety or quality of care.***

A work group chaired by MHA board member Jeffry Stampohar and comprised of 11 representatives of MHA members was convened in November. Work group members represented large and small hospitals and health systems, different areas of professional expertise and experience with regulatory burdens, and geographic areas of the state. The work group's roster can be found in Appendix A.

Work Group's Process

Over the course of November and December 2011, the work group met three times. The first meeting was used to establish the scope and urgency of the group's work, and to generate ideas of potential issues that could bring regulatory relief for Minnesota's hospitals. These ideas were catalogued and organized for comparison purposes. A chart of the regulatory relief proposals considered by the work group is attached as Appendix B.

During the second meeting, the work group discussed and evaluated the merits of the proposals. Members articulated proposals that required additional research before they could be fully understood. In addition, members were able to articulate their initial level of support or concern. This meeting also provided an opportunity for new ideas to be included on the list.

Finally, during the third work group meeting, members evaluated and set a priority — low, medium or high — to each proposal and provided feedback to MHA staff. Given time constraints, as well as the sphere of greatest influence of MHA, the work group focused its attention on regulatory relief proposals that can be adopted at the state level. Changes on the federal level were collected, too, with the intention that these suggestions be forwarded to the American Hospital Association for consideration.

During each meeting, the work group had robust discussions, particularly around the themes of provider licensure and credentialing, administrative simplification and data sharing.

Recommendations and Priorities

The work group recommended that the board of directors adopt as MHA's highest priorities in the area of regulatory relief, the following proposals for implementation. Generally categorized, the highest priority recommendations for state law changes fall into the following areas:

- Adopt more flexible health care professional licensing standards, including recognition of licensure by other states with suitable oversight processes.

- Streamline and consolidate reporting requirements, especially those financial data collected through the Hospital Annual Report and other reporting requirements that have similar but different standards than those required by national authorities.

- Ensure safe and efficient transmission of patient data between health care providers, providers and health plans, and providers and the state.

This report includes more detailed descriptions of the MHA Regulatory Relief Work Group's high- and medium-level priorities for changes at the state level, as well as suggested action steps.

High Priorities

1. Interstate Nurse Licensure Compact

> **Recommendation**
>
> The MHA Regulatory Relief Work Group recommends that MHA continue to support and actively advocate for enactment of these bills or other legislation that enrolls Minnesota in the Compact.

The Interstate Nurse Licensure Compact allows participating states to acknowledge nurse licensure granted by other states in the compact. As a result, licensed nurses can move to other states and begin working without being required to go through the whole licensing process all over again. It also allows nurses living in communities along Compact state borders to practice at clinics, hospitals or other facilities in both states without being required to obtain and maintain two separate licenses. Consequently, the Compact allows nurses to have greater flexibility in where they live and work, decreases nurses' total licensing fees and requirements, enables health systems with facilities in multiple states to deploy their nursing workforce as efficiently and fairly as possible, and reduces the total cost of health care by eliminating duplicative licensing processes.

Currently, 24 states participate in the compact, including all of Minnesota's bordering states: Iowa, North Dakota, South Dakota and Wisconsin.

MHA supports House File 462 and Senate File 230[1], which are bills introduced during Minnesota's 2011 legislative session. If enacted, these companion bills would make Minnesota the 25th state to adopt the nurse licensure compact.

2. Telemedicine licensure reform

> **Recommendation**
>
> The work group recommends that MHA begin building local and national support for changing the paradigm for health professional licensure to allow for more efficient interstate telemedicine practice.

The work group recommends that MHA support modernizing health care provider licensing to reflect the post-geographic reality of today's health care practices, particularly in regard to telemedicine. This reform proposal will allow physicians and other health care professionals to practice via telemedicine across state lines.

Telemedicine service is a valuable tool to provide greater access to health care for patients in underserved communities. Today, many patients suffer from otherwise preventable or manageable conditions because of a shortage of practitioners in their local community.

For example, rural communities often lack sufficient numbers of mental health providers to serve the residents. Yet, many mental health services can be provided remotely through telemedicine

1 https://www.revisor.mn.gov/bin/bldbill.php?bill=S0230.1.html&session=ls87.

technology, thereby allowing psychiatrists and other providers to provide care and treatment to patients in distant locations.

However, in order for a provider in another state to serve a Minnesota patient, today's laws require the provider to be licensed in Minnesota. This artificial and outdated limitation on the practice of medicine precludes optimal use and leveraging of telemedicine.

Recognizing a small piece of this limitation, the Centers for Medicare and Medicaid Services (CMS) promulgated new rules that allow a critical access hospital using telemedicine to deliver services from a provider at a different hospital to rely upon the other hospital's credentialing of that provider. The previous rule required each hospital to independently credential the provider[2], resulting in duplication of effort and presenting a practical obstacle to telemedicine implementation and deployment.

The work group recognized that effectively implementing its recommendation requires changes by other states in addition to modifications of Minnesota law. Therefore, the recommendation's scope exceeds the ordinary role of MHA and will require advocacy from other stakeholders. Nevertheless, the work group recommends that MHA begin pursuing the necessary changes in Minnesota while simultaneously seeking organizations with similar interests to pursue the kind of multi-state effort to effectuate this regulatory reform proposal.

One natural ally in this effort, the American Telemedicine Association, has begun a national campaign "to reform state-based medical licensing practices, which inhibit the efficient delivery of quality, modern healthcare."[3] The initiative, called Fix Licensure, has an online petition to Congress on this issue. Supporting and participating in the campaign is one option MHA could consider in its advocacy for telemedicine licensure reform.

3. Modify Provider Peer Grouping

MHA has a long and proud history of supporting and advancing transparency of relevant health care information, such as patient safety and quality measures. Underlying this long-standing position, however, is the assumption that the information to be made transparent must be accurate and adequately representative of what it is perceived to reflect. In other words, a quality measure must accurately reflect a provider's performance in that area in order for it to be useful when brought to light and made available to the public. Making misleading or inaccurate data transparent does not further the cause of greater transparency in health care.

Based on the provider peer grouping (PPG) information released to hospitals in September 2011, which was intended to be publicly reported 90 days later, work group members expressed significant concern about the PPG initiative's data and methodology. The data sent to hospitals were inaccurate and incomplete, and the methodology used to assess hospitals' performance artificially forced the appearance of performance variability when little or no variation existed from a statistical perspective. If published, the PPG results would have been inaccurate and misleading,

2 42 CFR Part 482 and 485.

3 http://www.fixlicensure.org/.

and therefore, the work group concluded that such publication would not further the cause of transparency as supported by MHA.

Subsequent to hospitals receiving their data, the Minnesota Department of Health (MDH) rescinded the reports and abandoned its intentions to publicly release those PPG results. The MHA Board of Directors directed staff to continue working with MDH to (1) improve and verify PPG data, (2) ensure that the PPG methodology is fair and reasonable, and (3) require that any appearance of variation between hospitals in the PPG results display reflect statistically significant differences in hospitals' performance. Until such thresholds and standards are met, the Board instructed staff to withhold the association's support of any public release of the PPG results.

Recommendations

The work group recommends that the MHA Board keep the option of pursuing legislation to repeal or replace the current statutory language establishing the PPG initiative.

If the Board decides to support replacing that language, the work group recommends supporting language that would require the PPG process and methodology development to go through a stakeholder-approved process, such as the process used by the National Quality Forum or Minnesota Community Measurement, prior to publicly releasing any PPG results.

Finally, at a minimum, the work group recommends that the MHA Board adopt the position that the association will seek legislation to eliminate the statutory requirement that PPG results be used in health plan design.

4. Reform annual financial reporting requirements

Every year, Minnesota's hospitals have the administrative burden and costs associated with completing the Hospital Annual Report (HAR). The HAR requires hospitals to report financial data using accounting methodologies that are inconsistent with those required for reporting to other authorities, including, but not limited to, the Internal Revenue Service (IRS) and the Centers for Medicare and Medicaid Services (CMS).

The MHA Regulatory Relief Work Group supports streamlining the HAR in order to advance administrative simplification and leverage the efficiencies that accompany consistent and common standards across reported information. The following examples of streamlining opportunities were identified by the work group as being of particular concern:

- **Capital expenditure reporting**

  Current law requires hospitals to complete a capital expenditure report for any capital project that is predicted to cost more than $1 million.

Recommendation

The work group recommends that MHA seek legislation to repeal hospitals' capital expenditure reporting requirement. Such legislation would repeal Minnesota Statutes section 62J.17 in its entirety or, in the alternative, subdivisions 3, 4a, 5a, 6a, and 7 of section 62J.17.

MHA staff were unable to identify any use of capital expense reports by the Minnesota Department of Health, which collects the reports, researchers or policy analysts, or other stakeholders. Accordingly, the work group considered the capital expenditure report requirement to be an example of an unnecessary and wasteful reporting burden. In 2011, the Legislature repealed the requirement that physician clinics report their capital expenditures through the Provider Financial and Statistical Report (PFSR)[4], which is similar to the HAR.

- **Community benefit reporting**

  Minnesota's hospitals report community benefit information to three government entities: the Internal Revenue Service (IRS) at the federal level, the Minnesota Attorney General's Office, and the Minnesota Department of Health (MDH). Exacerbating this duplicative reporting is the fact that these agencies have different reporting requirements for essentially identical information, thereby making these reporting requirements even more burdensome and costly, as well as potentially confusing for the general public.

  The IRS Form 990 with its new Schedule H is the most comprehensive and, because it is based on audited financial statements with uniform standards, should be sufficient for any mandated state reporting. While the Attorney General's Office allows nonprofits to submit their Form 990s to fulfill its reporting requirements, MDH continues to require reporting of virtually identical data according to its own standards and definitions.

  Going even further, legislation passed in 2011's special session purports to bestow new regulatory oversight powers to MDH in the area of community benefits.[5] According to this rider language, hospitals are required to submit their community benefit plans to MDH, and the agency has authority to "review and approve" those plans. Although the legislation fails to set forth any standards for MDH's approval or any limits on the penalties MDH can impose for failing to obtain such approval. Thus, hospitals and health plans have expressed concerns that the new language could lead to financial penalties or other sanctions on hospitals that do not expend the "right amount" of resources on community benefit activities or focus on the "right"

Recommendations

The work group recommends that MHA seek to repeal the new rider language empowering MDH to review and approve hospitals' community benefit plans.

Also, the work group recommends that MHA advocate for amendments to statutory and regulatory law to either eliminate community benefit reporting or, more likely, to regard a hospital's or health system's submission of its Form 990 Schedule H as sufficient to fulfill any state community benefit reporting requirements. These recommendations can be implemented by revising Minnesota Statutes sections 144.698-144.699, and Minnesota Rules 4650.0112, 4650.0115 and 4650.0117.

4 See Minn. Session Laws Ch. 9, Art. 2, § 29 (2011 Special Session) (repealing Minn. Stat. § 62J.41).

5 Minn. Session Laws, Ch. 9, Art. 10, § 4 (Special Session 2011).

community health needs, despite the results of their federally mandated community health needs assessments.

Several other proposed changes to the HAR were deemed to be medium priorities, and accordingly, are discussed below.

5. Align Minnesota's data privacy laws with federal law (HIPAA)

Minnesota's strict patient consent laws for releasing and sharing data between health care entities are hampering providers' ability to give high-quality care.[6] They also impede implementation of interoperable electronic medical records (EMRs), as well as a functional and efficient Health Information Exchange (HIE). Moreover, as health care delivery becomes increasingly competitive on a regional and national basis, these higher standards and limits on information exchange will put Minnesota's health care providers at a competitive disadvantage with their peers in other states who can exchange information more easily, more quickly and more affordably.

Recommendations

The work group recommends that the MHA Board authorize staff to seek legislation that will ease and modernize Minnesota's patient consent laws for health information disclosure to allow for better access to patient records for care delivery as well as implementation of interoperable EMR and HIE entities.

Also, the work group recognized that recent court decisions result in potentially higher standards for consent to retain genetic information, specifically the information associated with newborn screening[7], and agreed that MHA should support legislation to revise state law[8] to redress the court's ruling.

6. Reaction to professional licensure for unique services or functions:

Typically, each legislative session includes different health care employees asking the Legislature to impose professional licensure requirements for their particular services or functions. As both employers of these job classes and vendors of health care services, hospitals and health systems are caught in the cross-fire of these "turf" wars. On one hand, hospitals and health systems want to support their employees' interests in increasing the level of professionalism and training in their particular

Recommendation

The work group recommends that the MHA Board retain the 2009 evaluation criteria as the association's basis for future policy positions in response to proposals for new or additional licensure, education or training requirements for health care workers employed or affiliated with hospitals and health systems.

6 Minn. Stat. §§ 72A.501 and 144.293 (2011).

7 Bearder v. State of Minnesota 2011 WL 5554832 (Minn. 2011).

8 Minn. Stat. § 13.386 (2011).

field. And, on the other hand, hospitals and health providers need to wrestle the cost curve to slow the rate of health care cost increases and increasing education and licensure standards are accompanied by increased labor costs.

As a result, in 2009 the MHA Board adopted licensure proposal evaluation criteria developed by the MHA Policy and Advocacy Committee. The evaluation criteria are divided between situations in which the association will support proposals for new or additional licensure, education or training requirements; will oppose such proposals; or will remain neutral with respect to the proposals.

Support licensure if:

- Documented quality issues will be addressed
- Clear path for training adequate number
- Independent statewide committee studied issue and recommends licensure
- Financial analysis shows cost is worth benefit to public and patients

Oppose licensure if:

- No evidence that those currently performing functions in the field pose safety/quality problems
- Licensure will create workforce shortage
- Hiring restrictions affect hospitals only
- Other mechanisms already function to protect public; licensure is redundant

Neutral regarding licensure if:

- Hospitals are not affected

7. Adopt case-by-case evaluation of scope of practice issues

Scope of practice for health care professionals issues often involve two professional groups fighting over the ability to provide certain services. At other times, however, scope of practice issues involve aligning a profession's scope with their professional training, experience and abilities in light of modern medicine.

Recommendation

The work group recommends that the MHA Board employ a case-by-case evaluation of proposals to modify scopes of practice in order to balance and advance hospitals' and health systems' interests in safe, high quality and efficient care delivery.

Accordingly, the work group found it difficult to make uniform or across-the-board recommendations regarding proposals to adjust scopes of practice. Instead, it identified scope of practice concerns as significant regulatory impediments to efficient and safe delivery of care, as well as potential drivers of increased health care costs. Therefore, the work group felt that only a case-by-case evaluation should be used to establish MHA's position on scope of practice issues that arise.

8. Require health plans to include the two-digit Minnesota Health Care Program code on remittance forms

Recommendation

According to the work group, MHA should seek to require PMAP plans to include the two-digit program code on the remittance form (857) in order to decrease the administrative burdens associated with assisting DHS with its audits.

The particular state public program in which a patient is enrolled has a corresponding two-digit code. The Department of Human Services (DHS) provides this code to the Prepaid Medical Assistance Plans (PMAP plans) when an individual covered by a program enrolls in the PMAP plan. Minnesota's health plans then include this two-digit code on claims forms when they confirm the patient's enrollment and coverage, but they do not include it on payment remittance forms (Form 857). Consequently, hospitals are asked by DHS to do extensive administrative work to retrace their claims to identify state public program enrollees in particular programs who received hospital services and calculate the amount the hospital received in reimbursements for those services so that DHS can complete a disproportionate share hospital (DSH) payment audit required by the Centers for Medicare and Medicaid Services (CMS). If the two-digit code was included on the remittance form, hospitals could search their accounting records based on the necessary codes for those payments that qualify for DSH payments.

The administrative burdens for hospitals are so great that some organizations sought legislation allowing them to forego DSH payments entirely and, in return, avoid the costs and hassle of retrieving the information necessary for the CMS audit.[9]

9. Oppose changes in workers' compensation payment rules for implants

Recommendation

The work group recommends that MHA continue to oppose reverting to "cost-plus" reimbursement for implants, whether at the legislative or administrative level.

Minnesota's hospitals currently receive statutorily mandated charge-based reimbursement from workers' compensation insurers for implants. Workers' compensation insurance plans have long sought to revise this mandate from a charge-based to a "cost-plus" reimbursement system for implants. Historically, MHA has consistently and successfully opposed the insurers' efforts.

It seems likely that the issue will resurface in 2012 because the Department of Labor and Industry (DOLI) already contacted at least one MHA member regarding workers' compensation payments for implants.

9 See Minn. Session Laws, Ch. 9, Art. 6, § 60 (Special Session 2011).

Changing the reimbursement methodology to a cost-plus basis will reduce payments to hospitals. Furthermore, it will impose greater administrative burdens because hospitals will need to identify the actual invoice and cost of the particular implant used in the injured workers' care. With group purchasing and other supply cost management strategies, such requirements would be extremely difficult and costly to meet.

10. E-prescribing for controlled substances

> **Recommendation**
>
> The work group recommends that the MHA Board adopt a position in support of legislation that will conform Minnesota's electronic prescribing laws to the DEA's federal regulations to allow for controlled substance prescriptions to be made via electronic prescription processes.

The Federal Drug Enforcement Agency (DEA) issued new regulations that allow electronic prescribing of controlled substances. Previously, these prescriptions were required to be made on paper. Originally, this requirement was perceived to be a means of preventing the prescription from being used to obtain controlled substances illegally. However, with advancements in electronic prescription technology and more widespread adoption of the technology, the DEA recognized that allowing providers to use electronic prescribing for controlled substances will further the agency's objectives more than requiring paper prescriptions.

Although the DEA came to this conclusion, Minnesota law continues to require paper prescriptions for controlled substances. This requirement decreases the advantages and efficiencies of electronic prescriptions, increases costs for providers, makes the prescription process more inconvenient for patients, and no longer furthers the underlying security goals for controlled substances.

In 2011, House File 1520[10] included provisions[11] that would fulfill the work group's intended outcome. As a result, MHA could advance a separate bill that does not contain the other more controversial elements found in HF 1520 or seek to amend HF 1520 to retain the electronic prescribing provisions while eliminating those that make passage unlikely.

11. Modify state verbal order authentication regulations

The Centers for Medicare and Medicaid Services (CMS) previously required providers to authenticate verbal orders within 48 hours. In 2011, CMS reviewed its regulations in an effort to identify areas where federal rules could be eliminated or modified to reduce the government's expenses or provide regulatory relief to health care stakeholders. One of the changes CMS made was to modify the verbal order authentication rule to allow for much greater flexibility. Instead of setting a 48-hour deadline, CMS decided that providers' medical staffs could set their own policies

10 https://www.revisor.mn.gov/bin/bldbill.php?bill=H1520.0.html&session=ls87.

11 See §§ 3 and 4.

for requiring authentication of verbal orders in a timely manner unless state law prescribed a particular timeframe.[12]

Unfortunately, Minnesota rules adopted by the Department of Health (MDH) contain language requiring emergency orders provided over the telephone to be authenticated within 24 hours.[13] This rule not only undermines the federal government's effort to provide regulatory relief, but it makes the regulatory burden even higher than if CMS left its previous rule unchanged. Moreover, it runs counter to other regulatory language stating that any unwritten order needs to be authenticated within 30 days. The 24-hour deadline for authentication is unreasonable because on-call physicians do not always work within the 24 hours following their call. And, other physicians are understandably reluctant to authenticate a colleague's verbal order.

Recommendation

The work group recommends that the MHA Board take a position to advocate for (a) eliminating the rule regarding emergency telephone orders and 24-hour authentication requirement, (b) modifying the requirement to state that providers must comply with federal laws regarding authentication, (c) changing the rule to require authentication within 72 hours unless the organization's medical staff adopts a different policy that does not set a timeline longer than 30 days.

12 42 C.F.R. 482.24(c).

13 Minn. Rules Ch. 4640.0800.

Medium Priorities

1. Hospital Annual Report (HAR) modifications.

- **HAR, uncompensated care**
  Minnesota's hospitals must report their uncompensated care costs to the Internal Revenue Service (IRS)[14] and the Minnesota Department of Health (MDH).[15] However, MDH requires reporting of additional elements that are more burdensome to collect and calculate. In addition, there is no evidence that MDH or the public use these additional elements. Thus, the reporting requirement is burdensome and unnecessary.

  Recommendation: The work group recommends that MHA support legislation to conform MDH uncompensated care reporting with that used on the IRS Form 990.

- **HAR, administrative costs**
  The Minnesota Department of Health (MDH) requires hospitals to report their administrative costs in a way that does not conform to normal, widely accepted general ledger reporting.[16] This difference means an increase in time and costs for hospitals to recalculate their costs from one accounting methodology to another. Furthermore, the data reported every year by hospitals in this burdensome manner have yet to be used in an MDH report. Thus, the methodology required is expensive, burdensome, time-consuming and unnecessary.

  Recommendation: MHA should support amending the current administrative cost reporting statute to reflect normal general ledger reporting methodologies.

2. Health Information Exchange certification

Minnesota is the only state that requires its own certification for an entity to become a Health Information Exchange (HIE).[17] In addition, Minnesota has adopted a much more regulated environment that will govern a HIE once it is operational. This strict regulation scheme threatens to interfere with achieving interoperability of electronic health records, especially for providers located along the state's borders.

Recommendation: The work group suggests that MHA prefers a regulatory method similar to those in other states in which the government designates one HIE and then allows it much greater flexibility in its operations.

14 See IRS Form 990, Schedule H.

15 See Minn. Stat. § 144.698, subd. 1; Minn. Rules Ch. 4650.0115, 4650.0117.

16 See Minn. Stat. § 144.698, subd. 1; Minn. Rules Ch. 4650.0112, subpt. 3.

17 See Minn. Stat. §§ 62J.498, subd. 1(o)(3), 62J.4981, and 62J.4981, subd. 3.

3. Centralize and align quality improvement reporting and initiatives from multiple players

Hospitals and health systems face an uncertain future of payment reforms and accompanying requirements. With so many different payment reform initiatives and demonstration projects at the state and federal levels, it is challenging for hospitals to adequately and confidently prepare for what will be expected of them.

Recommendation: The work group recommends that MHA support aligning various quality improvement and payment reform initiatives where possible to provide greater certainty for Minnesota hospitals and health systems. Examples of such alignment efforts underway include the Reducing Avoidable Readmissions Effectively (RARE) campaign and the Statewide Quality Reporting and Measuring System (SQRMS).

4. Physician credentialing by health plans

Physicians often wait weeks, sometimes as long as 90 days, to complete health plans' credentialing processes. During that time, physicians are unable to receive reimbursement for services provided to the health plan's patients. This delay results in significant revenue loss for providers, as well as an unnecessary reduction in capacity. This is particularly problematic in rural communities where patients might need to reschedule services or travel much further to get them while a qualified, available and willing provider sits idle in their community.

Recommendations:

- The work group suggests that MHA adopt the position that a provider should be eligible for retrospective reimbursement for any services delivered to a health plan's enrollees after submitting his/her credentialing information to the plan if the plan later credentials the provider. If the plan determines that the provider fails to meet the credentialing criteria, no reimbursement for services provided during the interim would be required.
- According to the work group, MHA should encourage health plans to provide "deemed status" to more hospitals and health systems so that the credentialing process does not need to be duplicated and credentialing delays can be mitigated.
- The work group encourages the MHA Board to support enhancing the Minnesota Credentialing Collaborative's (MCC) services to include primary source verification, and then, to serve as a statewide "deemed status" credentialing mechanism while leaving privileging decisions to local providers.

5. Health plan administrative issues

MHA members report problems and lost revenues because some health plans do not use the complete billing codes on all claims, and instead, truncate the claim after a certain number of coded services. Members also report instances in which health plans unilaterally "regroup" providers mid-contract and without providers' knowledge. Finally, members report receiving fee schedules in an untimely manner.

Recommendations:

- The work group suggests that MHA support using the Administrative Uniformity Committee's (AUC) process to address these and other health plan administrative concerns. However, this process must move expeditiously.
- The work group recommends that MHA support House File 1185[18], which would mandate a timeline for health plans to provide a fee schedule to providers.

6. Standardize administrative simplification rules for workers' compensation claims with those required of other payers

Workers' compensation insurance companies are exempt from some of the administrative simplification rules resulting from the landmark legislation championed by MHA in 2007. This exemption creates administrative hurdles and inconsistencies for hospitals and health systems at a time when the focus should be on administrative simplification and uniformity.

Recommendation: The work group recommends that MHA work through the Department of Labor and Industry, the Workers' Compensation Advisory Council and the Administrative Uniformity Committee to address these simplification and standardization concerns.

7. Align with federal law or consider sunsetting the agreement with Minnesota's attorney general

MHA has suggested changes to the most recent version of the debt collection and fair billing agreements with the Attorney General's Office. MHA's suggestions include revisions that reflect federal standards adopted in the Patient Protection and Affordable Care Act in 2010. In light of the new federal protections, some work group members questioned the utility of extending the state agreement.

Recommendation: The work group recommends that MHA continue negotiating in good faith with the attorney general with a priority on ensuring that hospitals and health systems can easily and simultaneously comply with federal regulations and any agreement with the attorney general.

18 https://www.revisor.mn.gov/bin/bldbill.php?bill=H1185.0.html&session=ls87.

Appendix A: Committee Roster

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Appendix B: Priority Chart

Minnesota Hospital Association

Appendix B

Priority	Proposal	State	Federal	Pros	Possible Opponents	Additional Information
High	Interstate licensure compacts • Nurse Licensure Compact	State statute change and probably rule changes		Simplifies administrative work and increases workforce flexibility for border members.	MNA already opposed; small impact on state budget from lost licensing fees	MHA supports Nurse Licensure Compact legislation. (HF 462/SF 230; https://www.revisor.mn.gov/bin/bldbill.php?bill=S0230.1.html&session=ls87) 24 states are currently part of the compact: AR, AZ, CO, DE, IA, ID, KY, MD, ME, MO, MS, NC, ND, NE, NH, NM, RI, SC, SD, TN, TX, UT, VA, WI
High	• Physician Licensure Compact	State statutory change; drafting compact; advocating adoption by other states		Simplifies administrative work, reduces recruiting costs and delays; increases workforce flexibility; increases care delivery flexibility by allowing physicians to practice telemedicine across state lines.	MMA; unknown impact on state budget from lost licensing fees	National push for telemedicine standard? Yes – the American Telemedicine Association launched an initiative "to reform state-based medical licensing practices, which inhibit the efficient delivery of quality, modern healthcare." http://www.fixlicensure.org/, http://www.americantelemed.org
High	Repeal Provider Peer Grouping OR Moratorium on releasing information until a better methodology is in use. "Repeal and replace"	State legislative change 62U.04		Prevent inaccurate and misleading data from being used by plans and consumers; reduce state spending	MDH, some business groups	MHA working with MDH to ensure accurate data and reasonable methodology Verifiability of the accuracy of the underlying data is the key issue. Current methodology has flawed cost/acuity adjustment data.
High	Streamline Hospital Annual Report (HAR) or have MDH use audited financial statements	Statutory and MDH rules changes Minnesota Statutes 2011 sections 144.698-144.699 and Minnesota Rules chapter 4650.0112, 4650.0115 and		Eases reporting burden, creates more consistency across reported information	Less timely data; potential costs for MDH to adjust its systems; lack of continuity with previous years	Would/could physicians support?
Medium	• Uncompensated care			Already reported on 990	MDH argues that data are needed for research	

	reporting (HAR sec. 14)	4650.0117; Minnesota Laws 2011, 1st Special Session, Chapter 9, Article 10, section 4		Some elements are unique, requiring more administrative burdens or estimates No evidence that unique elements are ever used by MDH or public	and policy	
Medium	• Administrative costs (HAR sec. 18-20)			Does not conform to normal general ledger reporting Difficult, costly to report Data is non-public so only MDH has access and has not used it for any reports Extra burden, cost Data not used MDH agrees it is unnecessary	MDH argues that data are needed for research and policy	
High	• Capital expenditure reporting (HAR sec. 56-57, and table "Capital Expend Project Specific")			Already reported on 990 and to AG Different definitions than IRS IRS is more comprehensive	MDH argues that data are needed for research and policy	Need to ensure reporting is confined to the hospital's community benefit, not the entire organization's.
High	• Community benefit reporting (HAR sec. 21) and new MDH language					New MDH requirements are also on Policy and Advocacy Committee agenda

High	Refrain from professional licensure for niche services	Block attempts to change statutes		Reduces workforce costs, allows more flexibility in hiring and staffing, avoids diminished workforce supply	Employees and other health care workers seeking licensure; potentially higher ed institutions with programs	MHA adopted evaluation criteria in 2009: Support licensure if: • Documented quality issues will be addressed • Clear path for training adequate number • Independent statewide committee studied issue and recommends licensure • Financial analysis shows cost is worth benefit to public and patients Oppose licensure if: • No evidence that those currently performing functions in the field pose safety/quality problems • Licensure will create workforce shortage • Hiring restrictions affect hospitals only • Other mechanisms already function to protect public; licensure is redundant Neutral regarding licensure if: • Hospitals are not affected Lab licensing likely to come back in 2012. Propose/support licensing moratorium language?
High	Change or refrain from changing scope of practice limits on case-by-case basis (avoid using scope of practice to block other competent providers from delivering service)	State legislative or rule change				Different than initial license (see MHA criteria for support, opposition, or neutrality on licensing proposals) This is expansion or change in scope of practice, like the APRN coalition to eliminate the collaborative agreement.
High	Align MN's laws government privacy of data with federal standards. Ease or modernize requirements for patient consent regarding medical records.	State legislative change, 72A.501 and 144.293, possibly 13.386 (genetic information)		Provide more certainty around data use and privacy standards: bring MN in line with other states; allow for full impact from EMRs	Privacy/consumer advocates; some providers of services associated with social stigmas (e.g., CD, MH)	Areas of discrepancy: • Annual patient consent required under MN law • Patient consent required to send records between providers (with certain exceptions) under MN law • Federal standard: treatment, operations, payment

High	Require health plans to include the 2-digit code identifying state public program enrollee's program, require health plans to provide data necessary for state to complete DSH audits or require state to complete DSH audits with its own data (e.g., all-payer database)	State legislative or rule change or administrative action		Allow hospitals to identify services provided to state public program enrollees in PMAP and calculate payments received for auditing purposes	Health plans that don't want to bear reprogramming costs	MHA has advocated for rule change at AUC Plans provide this information on the claim, but not the remittance. Some plans are including on the 5010.
High	E-prescribing • Who meets? • Overlap with meaningful use • Hardship period • CPOE	State legislative change	Federal regulatory change (meaningful use)	Already difficult to justify expense for some pharmacies, especially in rural areas Avoid noncompliance penalties when compliance isn't possible or the result of the providers' omissions	Need to make sure that both state and federal requirements mirror one another (tough) ONC is very committed to keeping this standard in meaningful use Once exempted, difficult to generate any incentive for adoption	HF 1520, sections 3-4, allows for e-prescribing of controlled substances. https://www.revisor.mn.gov/bin/bldbill.php?bill=H1520.0.html&session=ls87 Supported by Board of Pharmacy, Pharmacist Association, and law enforcement.
High	Modify state verbal order recording regulations	State (need citation)		MNA?	DHS	CMS had previously superseded the 24-hour limit with a 48-hour limit that was also too restrictive. When CMS rescinded this timeframe, Minnesota's 24-hour limit went back into effect.
Medium High for implant legislation	Standardize workers' compensation rules with other payers (administrative simplification)	State legislative or rule change Oppose implant legislation			Workers' comp companies who are currently exempt	Department of Labor and Industry (DOLI) Revision of implant payments back to cost plus?
Medium	Health Information Exchange (HIE) certification (MN only state with approval requirement)	State statutory change 62J.498, sub. 1 (o)(3), 62J.4981, and 62J.4981 sub. 3			MDH, DHS	Other states designate one HIE entity but allow greater flexibility in operation. Minnesota much stricter in certification and once HIE in place – could this be a problem for CMS? MN has only received planning money, no more. There is also a problem for border state providers requesting medical records.

Medium	Impose maximum response time for physician credentialing by health plans (similar to timely claims filing requirement on providers) or require health plans to pay retrospective claims generated by provider who submitted credentialing application but had not yet been credentialed	State legislative change		Allow hospitals to begin using physicians and billing for services if confident about their credentialing application; likely to have support from MMA and MDA	Health plans	Some providers have up to a 90 day wait from plans. MCC to address. • Need to create a primary verification to allow provider to practice while awaiting full credentialing. • Burdensome process that seems capable of simplification • Independent provider at 5 hospitals shouldn't have to go through 5 credentialing processes • "Deemed status" clearing house for credentialing; leave privileges for hospital to determine • Allow/require more "deemed providers" for credentialing by health plan credentialing
Medium	Require payers to use all codes on claims, not just 4 or other truncation	State legislative or rule change or administrative		Allow for more complete and accurate billing process	Health plans that truncate or may truncate in the future	AUC
Medium	Prohibit health plans from changing information (regrouping) on providers	State legislative or rule change or administrative		Create more certainty in billing process and avoid decreased reimbursement	Health plans; business community	AUC
Medium	Increase standardization of billing/claims process even beyond 2007 legislation	State legislative or rule change				HF1185 – fee schedule https://www.revisor.mn.gov/bin/bldbill.php?bill=H1185.0.html&session=ls87
Medium	Centralize and align quality improvement reporting and initiatives from multiple players	State legislative or rule change Also SEGIP				Payment reform requirements are driving much of the alignment attempts. Current alignment projects include RARE and SQRMS Statute allows plans to use for pay for performance; providers can use as well for own initiatives. MMB report group asked to examine the logic behind having mandatory reporting for CAH.
Medium	Align or consider sun-setting MN AG agreement in light of federal ACA	Negotiation with MN AGO				MHA in negotiation process with AG; however, AG is unlikely to sunset or end the agreement. Is this working now? Is there a collection agency problem?

Low	Standardize/uniform risk-adjustment methodology for plans and care management in Minnesota	Either state statutory change or voluntary action by health plans		Create more certainty in care management for providers, more uniformity in impact of various payment incentives	Health plans that have invested in and developed payment structures around different methodology; potentially DHS if it uses different methodology	3 different models are currently used: • Optim • Johns' Hopkins (ACG, used by DHS) • Federal government model Attribution model is also an issue Discussions have taken place at Minnesota Community Measurement
Low	Simplify, streamline trauma system reporting and staffing requirements (contrast with heart system)	State has a Heart Disease and Stroke Prevention system (best practices, not statute) Trauma system governed by MS 144.602-144.608, 144E.101			EMTs MDH and EMSRB	Historically, MHA has supported trauma system MnSTAR Waconia working with state trauma task force to find improvements.
Low	Facility/construction inspections – duplicate inspections and fees for various approvals	State legislative change or department behavior modification		Reduce duplicative and unnecessary inspections, thereby cutting construction costs	Inspectors, impact on state budget	Timing of multiple and MDH inspections key issue – can delay getting certificate of occupancy
Low	Health care homes (HCH) reporting, renewal process	State legislative or rule change				MMA is interested in renewals Important difference between being enrolled in a HCH and going to a HCH-certified clinic.
Low (addressed in another group)	Ease placement of mental health patients who also present with chemical abuse issues	State legislative or rule change				Mental and Behavioral Health Task Force
Low	Develop construction standards or building codes for free-standing endoscopy centers so they don't have to be built to higher-than-necessary standards	State legislative or rule change, one-on-one conversations				
Low	Simplify and make more user-friendly the process for recertification of	Need more information on what is being requested, including renewal	CMS			Awaiting additional information

	hospital, nursing home, home health, etc. Currently required every 4 years, can't get copy of previously submitted materials, 64 pages.	application. Nursing homes and home health providers renew licenses annually. Nursing homes surveyed every 2 years, home health longer.				
Low	Traumatic Brain Injury Registry			Ease reporting burdens	TBI advocates, researchers, public health	Awaiting additional information
Low	Cancer Survivor System			Ease reporting burdens	Cancer advocates, researchers, public health	Awaiting additional information

Additional Items and Federal Items

	Hazardous waste management: redundant fees					Awaiting additional information
	Data usage requirements (privacy)					Awaiting additional information
	Reduce elevator inspections of existing, functioning elevators					Awaiting additional information
	Plans' reimbursement requirements for billing licensed professionals					Awaiting additional information
	Human resources reporting requirements to state?					Awaiting additional information
	Ease reporting requirements for grants					Awaiting additional information
	Drug formulary prior authorization					Awaiting additional information
	Claims attachments					Awaiting additional information

	AUC update • MMB inventory of recommendations • Meeting summaries					Awaiting additional information
	Pre-authorization at point of care as opposed to central location within system					Awaiting additional information
	Recognize number of procedures by identical team when health plans or other independent organizations designate centers of Excellence					Awaiting additional information
	Eliminate restriction of one billable mental health service per day (state or plan?)	State legislative or rule change (still seeking specific statutes or federal law)	CMS			Correct coding initiative is CMS, Medicaid, etc. coding issue; Then, for MN plans, the "one event per day" billing depends on the provider, the services being provided, and the reimbursement method. FQHCs and hospital outpatient most likely to have this issue. (FQHCs have problem for other services as well.) Apparently goes back to whatever coding initiative happens to be in place.
	Barriers for clinical integration		CMS, FTC			MHA and AHA advocating for changes
	Physician supervision policy in outpatient payment rule		CMS			MHA and AHA advocating for changes
	Ease restrictions or requirements concerning the separation of space/signage between urgent and emergency room care		CMS			

	Eliminate ACA's future requirement for PPS hospitals to have a contract with a patient safety organization		Federal statutory change			
	Modify the meaningful use implementation requirements to acknowledge limited resources available resources (vendor capacity, spending for deadlines rather than value)		CMS			Possible recommendation: seek regulatory change allowing provider to attest or certify that it is in a vendor's queue and have sufficient obligation on provider and vendor to complete project.
	Reduce burden/increase flexibility for Community Health Needs Assessments		Congress or IRS			
	Clarify observation bed status and Medicare payment for long-term care		CMS			
	Clarify, set uniform accounting guidelines for paired kidney exchange events		CMS			
	Amend critical access hospitals' conditions of participation to recognize "virtual" presence of physician for ER or other outpatient services		CMS			
	Community health needs assessment		CMS			Allow regional or network assessments instead of only single hospital entity. MHA included recommendation in comment letters.